

Mail Service Prescription Enrollment Order Form

For participants in the Top, Intermediate, and Basic PPO Plans

This form is to be used by participants enrolled in any of the following plans: Top PPO Plan, Intermediate PPO Plan, or Basic PPO Plan. This form is to be used to obtain maintenance prescriptions through the Mail-Order Program. The mail-order program is administered by PharmaCare Direct.

If you have never used the Mail-Order Program before with PharmaCare, you must complete all sections of this form (including the confidential patient profile), and sign and date the form. If you have used PharmaCare in the past, you can either use this form to order more prescriptions, or use the order form you received with your prescription order from PharmaCare. You need to sign and date the form. If you have completed a Mail Service Prescription Enrollment Order form previously, you only need to complete the confidential patient profile section if any of the information has changed.

Co payments are as follows:

2004 Express Pharmacy Copayments (for up to a 90-day supply)		
	Top & Intermediate PPOs	Basic PPO
Generic	\$13 copay	\$15 copay
Brand Name	<i>Preferred</i> - \$43 copay <i>Non-Preferred</i> - \$75 copay	<i>Preferred</i> - \$43 copay <i>Non-Preferred</i> - \$75 copay

If you have any questions about what is on the preferred drug list, call EHS at 888-249-5041.

Please mail the form, co-payment, and the original prescription(s) to:

PharmaCare Direct
P.O. Box 270
Pittsburg, PA 15230-9949

You can expect delivery of your order within 14 calendar days from the date you mailed it.

MAIL SERVICE PRESCRIPTION ENROLLMENT ORDER FORM UCI

Member Name _____

Sandia National LaboratoriesAddress _____
Street City State Zip

Daytime Phone () Home Phone ()

Member Number/Social Security Number _____

CONFIDENTIAL PATIENT PROFILE

Member _____ Date of Birth _____ Sex ☐M ☐F
 Last Name First MI
Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
 Other health conditions/allergies _____
 *Indicate the type of supplies being used - _____
 Monitor Lancets Test Strips

Spouse _____ Date of Birth _____ Sex ☐M ☐F
 Last Name First MI
Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
 Other health conditions/allergies _____
 *Indicate the type of supplies being used - _____
 Monitor Lancets Test Strips

Dependent _____ Date of Birth _____ Sex ☐M ☐F
 Last Name First MI
Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
 Other health conditions/allergies _____
 *Indicate the type of supplies being used - _____
 Monitor Lancets Test Strips

Dependent _____ Date of Birth _____ Sex ☐M ☐F
 Last Name First MI
Allergies (check boxes) ☐None ☐Penicillin ☐2 Chocolate ☐3 Sulfa ☐4 Aspirin
HEALTH CONDITIONS ☐5 Thyroid ☐6 Diabetes* ☐7 Glaucoma ☐8 Heart Condition ☐9 High Blood Pressure
 Other health conditions/allergies _____
 *Indicate the type of supplies being used - _____
 Monitor Lancets Test Strips

PLEASE READ AND SIGN: I certify that the information provided on this form is correct and that the prescriptions enclosed are for use by eligible participants. I certify that I or my dependents for whom prescriptions are enclosed do not have primary prescription drug coverage under any other group medical plan. I also certify that the enclosed prescriptions are not eligible for reimbursement under a Worker's Compensation Program. I authorize the release of all information to the Plan sponsor, administrator or underwriter.

Member Signature _____ Date _____

PRESCRIPTION ORDER FORM FOR NEW PARTICIPANTSPrescriptions are for: ☐Member ☐Spouse ☐DependentChildproof caps are used for safety in shipping. ☐Check here if you want non-childproof caps with this order.

Please write the member number on the back of each prescription.

Brand-Name Prescriptions**Generic Prescriptions**

Payment is being made by:

☐Check☐Money Order☐Credit Card

Please make check or money order payable to:

PharmaCare Direct.

Do not send cash.

Quantity: _____

Quantity: _____

Copay: \$ _____

Copay: \$ _____

Total: \$ _____

Total: \$ _____

If paying by credit card, indicate the credit card you wish to use and provide the account number and the expiration date:

☐JCPenney☐Novus/Discover☐Master Card☐VISA☐American Express

Credit Card Account Number: _____

Expiration Date: _____

Signature of Credit Card Owner: _____

Date Signed: _____

UCI